Maryland WIC Program Referral Form

<u>To the health care provider</u>: Please use this form to refer your patients to WIC and to request special formulas. You may skip the sections that are not relevant.

Patient's Name _____ Date _____

Medical Data:

	Length/Height	Length/Height Percentile (infant/child)	Weight	Weight Percentile (infant/child)	Weight/Height Percentile (infant/child)	Hgb or Hct	Blood Lead	Glucose (if gestational diabetic)
Date measured								

Women: Pregnant: Estimated date of delivery _____

Post-partum: Date pregnancy ended _____

Is this mother breastfeeding her infant? Γ Yes Γ No

Medical nutritional supplement (if applicable) _____
*(*Requires MD/DO/CNM/CNP/PA Signature)*

Infants/ Children: Parents/Guardian's Name _____

Feeding Prescription (if applicable)

Γ Breastmilk Γ Enfamil with iron Γ Prosobee

Γ Enfamil Lipil with iron Γ Prosobee Lipil Γ LactoFree Lipil

Γ Special Formula Request ⇨ ⇨ ⇨ ⇨ Formula Name: _____

*(*Requires MD/DO/CNP/PA Signature)* _____

Formula Prescription valid for _____ month(s)

Medical Diagnosis for Formula:

_____

A special request formula will be considered only when both Enfamil with iron (Enfamil Lipil with iron, or Lactofree Lipil) and Prosobee (or Prosobee Lipil) are inappropriate due to a documented medical reason. Please note that WIC may not always be able to provide the product you prescribed. Non-specific symptoms such as intolerance, fussiness, colic, spitting up, gas, and constipation will not be considered indications for a special formula.

Please check symptoms of intolerance that apply:

Γ Chronic diarrhea Γ Chronic/persistent emesis
Γ Persistent rash Γ Persistent respiratory condition
Γ Anaphylactic reaction Γ Documented allergy (specify: _____)

Health Care Provider's Signature _____
(MD/DO/CNM/CNP/PA with prescriptive authority signature required if requesting special formula or medical nutritional; RD/LD/RN/LPN may sign when providing medical data only.)

Health Care Provider's Name _____ Phone Number _____
(please print)

For WIC use only:
Date Received _____ Γ Formula Approved
Γ Formula Denied CPA Signature _____